

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/02/2024
NAME OF PROVIDER OR SUPPLIER  Luxe at Wellington Rehabilitation Center The		STREET ADDRESS, CITY, STATE, ZIP CODE  10330 Nuvista Avenue Wellington, FL 33414	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746</b></p> <p>Based on record review and interview, the facility failed to issue refunds due to 1 of 1 sampled resident (Resident #1) representative within 30 days of the Resident's death.</p> <p>The findings included:</p> <p>Review of Resident #1's clinical record on [DATE] documented Resident #1 was admitted to the facility on [DATE]. Her admitting diagnoses included Coronary Artery Disease, Anxiety Disorder, and hypertension. The Clinical record also revealed that Resident #1 was admitted to the facility for skilled rehabilitation services which included physical therapy, occupational therapy, and respiratory therapy.</p> <p>In an interview conducted with Resident #1's Representative on [DATE] at 9:17 AM, he reported that Resident #1's skilled services ended [DATE], as she reached her maximum physical potential. Resident #1's Representative who verified having power of Attorney (POA), by providing a copy of the document to the surveyor, said that he decided to personally pay for continued skilled services. He paid the sum of \$2550.00 dollars, on [DATE] to extend the skilled rehabilitation services which he thought Resident #1 still required. However, Resident #1 was discharged and sent to the hospital the same night of [DATE], necessitating higher level of care due to respiratory distress. However, she did not return to the facility, Resident #1 died on [DATE].</p> <p>Subsequently, Resident #1's Representative said on February 1, 2024, he contacted via telephone and spoke with a former staff member of the facility who was then the Business Office Manager (BOM) regarding obtaining a refund for the sum of \$2,550.00 dollars, which he had paid. But, after waiting more than a month with no feedback from the facility, he telephoned the facility to find out what was going on. He then found out that there was a new BOM at the facility. He said that he spoke over the phone with the new BOM who promised him to look into the situation and to call him back after a few days. However, the new BOM did not call him back.</p> <p>The Representative continued and said that he then returned to the facility in the month of [DATE] (no exact date provided) to inquire about the refund. When he got there, the Receptionist told him that the Administrative staff was in a meeting and there was no one available to talk to him. He was told that someone would call him back. Still, no one did. Resident #1's Representative said that he complained to different staff including the Administrator, the BOM, and whoever would listen, but as of [DATE], he received no refund and no callback.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview conducted with the BOM on [DATE] at 12:02 PM, she reported that she started working at the facility on the 23rd of [DATE]. The BOM informed that she recalled speaking with Resident #1's Representative by phone, about the refund. The BOM said since she was not familiar with the issue, she inquired about it from the Regional Office, because there were no notes written about the claim for a refund in Resident #1's financial record. During her inquiry, the BOM said she found out that Resident #1 had died even before she started working at the facility. The BOM said she sent an email to the Regional Field Office Analyst (RFOA) right after, for them to follow through with the Representative's refund claim. The BOM said she did not know what else happened., She did not follow through.</p> <p>On [DATE] at 11:51 AM, the Administrator said that he officially started working at the facility in [DATE]. Before that date he served as Interim Administrator from February 2024 up to his official starting date. The Administrator confirmed that he did receive a voice message on his voicemail from Resident #1's Representative requesting a refund while being Interim Administrator (no exact date provided). However, the Administrator explained that since he was new to the facility and did not know what the issue was, he had forwarded the message to the business office for follow-up. The Administrator said that he did not call Resident #1's Representative back. He thought the issue would have been addressed by the business office. The Administrator said he did not file a grievance on behalf of Resident #1.</p> <p>On [DATE] at 3:21 PM The Grievance Officer/ Social Service Director reported in an interview that she has been working at this facility since September of 2022. The Grievance Officer said she did not know anything about Resident #1's Representative's request for a refund. She further stated after reviewing her notes, she had nothing documented regarding that issue.</p> <p>As a result of the Surveyor's intervention, on [DATE] at 12:28 PM, the Administrator said that he sent an email to the Regional [NAME] President of Operations (RVPO) to further inquire about the situation. Later that day, the Administrator reported that the RVPO informed him that they were going to expedite the refund check to the Resident's son that same day. In all, the facility returned Resident #1's refund to the Representative after 188 days.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31746</p> <p>Based on record review and interview, the facility failed to document and act upon grievances reported by 2 of 2 sampled residents (Resident #1 &amp; Resident #2) and or their representatives in a timely manner.</p> <p>The findings included:</p> <p>Record review of the facility's grievance policy and procedures revised on ,d+[DATE], Section #3, outlined that All grievances, complaints or recommendations stemming from resident or family, groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to verbally and/or in writing upon request including a rationale for the response. Section #7 of the policy outlined the Administrator has delegated the responsibility of grievance and or complaint investigation to the Grievance Officer.</p> <p>1) Review of Resident #1's clinical record on [DATE] documented Resident #1 was admitted to the facility on [DATE]. Her admitting diagnoses included Coronary Artery Disease, Anxiety Disorder, and hypertension. The Clinical record also revealed that Resident #1 was admitted to the facility for skilled rehabilitation services which included physical therapy, occupational therapy, and respiratory therapy.</p> <p>In an interview conducted with Resident #1's Representative on [DATE] at 9:17 AM, he reported that Resident #1's skilled services ended [DATE], as she reached her maximum physical potential. Resident #1's Representative who verified having power of Attorney (POA), by providing a copy of the document to the surveyor, said that he decided to pay out of his own pocket for continued skilled services. He paid the sum of \$2550.00 dollars, on [DATE] to extend the skilled rehabilitation services which he thought Resident #1 still required. However, Resident #1 was discharged and sent to the hospital the same night of [DATE], necessitating higher level of care. However, she did not return to the facility, Resident #1 died .</p> <p>Subsequently, Resident #1's Representative said on February 1, 2024, he spoke with a former staff member of the facility who was then the Business Office Manager (BOM) regarding obtaining a refund for the sum of \$2,550.00 dollars which he had paid. But, after waiting more than a month with no feedback from the facility, he called to find out what was going on. He then found out that there was a new BOM at the facility. He said that he spoke over the phone with the new BOM who promised him to look into the situation and to call him back after a few days. However, the new BOM did not call him back.</p> <p>The Representative continued and said that he then returned to the facility in the month of [DATE] (no exact date provided) to inquire about the refund. When he got there, the Receptionist told him that the Administrative staff was in a meeting and there was no one available to talk to him. He was told that someone would call him back. Still, no one did. Resident #1's Representative said that he complained to different staff including the Administrator, the BOM, and whoever would listen, but as of [DATE], he received no refund and no callback.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview conducted with the BOM on [DATE] at 12:02 PM, she reported that she started working at the facility on the 23rd of [DATE]. The BOM informed that she recalled speaking with Resident #1's Representative by phone about the refund. The BOM said since she was not familiar with the issue, she inquired about it from the Regional Office, because there were no notes written about the claim for a refund in Resident #1's financial record. During her inquiry, the BOM said she found out that Resident #1 had died even before she started working at the facility. The BOM said she sent an email to the Regional Office for them to follow through with the Representative's refund claim. The BOM said she did not know what else happened, she did not follow through.</p> <p>On [DATE] at 11:51 AM, the Administrator reported that he officially started working at the facility in [DATE]. Before that date he served as Interim Administrator from February 2024 up to his official starting date. The Administrator confirmed that he did receive a voice message on his voicemail from Resident #1's Representative requesting a refund while being Interim Administrator (no exact date provided). However, the Administrator explained that since he was new to the facility and did not know what the issue was, he had forwarded the message to the business office for follow-up. The Administrator said that he did not call Resident #1's Representative back. He thought the issue would have been addressed by the business office. The Administrator said he did not file a grievance on behalf of Resident #1.</p> <p>On [DATE] the Surveyor reviewed the facility's grievances log and recorded complaints from February 2024 to [DATE]. There was no documentation of Resident #1 Representative's complaints regarding a request for a refund. Although Resident #1's Representative said that he made several attempts to obtain the refund and reported his complaints to different staff members, no one recorded his complaint in the grievance log.</p> <p>On [DATE] at 3:21 PM The Grievance Officer/ Social Service Director reported that she has been working at this facility since September of 2022. The Grievance Officer said she did not know anything about Resident #1's Representative's grievance/complaint about a refund. She further stated after reviewing her notes, she had nothing documented regarding Resident #1's Representative request for a refund.</p> <p>2). Review of Resident #2's electronic clinical record revealed she was admitted to the facility on [DATE]. Her admitting diagnoses included status post abdominal surgery, paraplegia, hypertension, Neurogenic bladder, and malnutrition. Review of Resident #2's minimum data set (MDS) section C, revealed a Brief Interview of Mental Status (BIMS) dated [DATE] which documented a score of ,d+[DATE] obtained by Resident #2. This BIMS score reflected Resident #2's cognitive ability, her status of being alert and oriented to person, time, and place.</p> <p>Review of the MDS section GG dated [DATE] documented that Resident #2 was dependent on staff for toileting needs, required substantial assistance for lower and upper body dressing, shower/bathing, bed mobility (roll left to right; lying to sitting on the side of bed; she was dependent on staff to put on her shoes, to stand from a sitting position, and for chair to bed transfer. Resident #2 could not walk. The record further indicated that Resident #2 was admitted for skilled rehabilitation services. Section O of the MDS documented that Resident #2 received two days of skilled rehabilitation services (physical therapy &amp; occupational therapy).</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #2's Representative reported on [DATE] at 8:34 AM and 8:40 AM respectively, that he reported his dissatisfaction to the facility during his mother's admission to the facility which was around [DATE]. Resident #2's Representative informed that during his mother's first day at the facility she was supposed to be on bed rest until she could be assessed by the physical therapy department. The Representative claimed on the contrary they stuck her mother in a wheelchair &amp; left her there for 4 hours in pain. He said that no one listened to her. The Representative stated that it took many hours before someone listened and put her to bed.</p> <p>Resident #2's Representative also said that around [DATE], his mom called him at 1am. She could not sleep because she could not turn the lights off. She kept ringing (her call light) for help, but no one came. The Representative said that He had to call the nurse's station and 4 hours later, someone finally came and turned the room lights off. The Representative did not explain how he knew that it took 4 hours.</p> <p>Resident #2's Representative continued and reported that on [DATE], after dinner, Resident #2 started experiencing nausea, vomiting, &amp; pain in her stomach. She also felt very hot &amp; miserable. Again, nobody responded to her call light. The Representative said that his mother called him at 3 A. M. He called the nurse's station again &amp; complained that his mom had been calling them. He told them to go check on her. Two minutes later, a nurse called back saying she was fine, just hot, but okay. The Representative said, It didn't seem like she really checked on her at all. The next day, the Representative said he went by the facility at 9:00 A.M, to see Resident #2. The Representative said he found Resident #2 bloated, hot, &amp; spitting up. Representative #2 said he complained to the nurses and asked to speak with the doctor. He told them she had been like that all night, and no one was helping her. The Representative said the doctor thought Resident #2 might have had a blockage in her intestines or stomach, so he ordered that they call 911. Resident #2 was immediately sent to the hospital.</p> <p>On [DATE], review of the facility's grievance log from [DATE], to [DATE], revealed no documentation of Resident #2's Representative's complaints/grievance. There was no entry for Regarding Resident #2's representative complaints for lack of care, call light response in the grievance log.</p> <p>The Administrator stated on [DATE] at 3:32 PM, after residents are discharged from the facility, they usually call them to follow-up and conduct a satisfaction survey with them. During the follow-up call to Resident #2's Representative on [DATE], they became aware of the Representative's complaints. The Administrator said that they immediately initiated a full complaint investigation to determine what had occurred the night of [DATE]. Despite the facility initiating a grievance investigation on [DATE], there was no entry made on of the grievance log to reflect Resident #2's Representative grievances. The Administrator said that they forgot to add Resident #2's complaints and update the grievance log.</p>		